Review and Continued Enrollment

Ask Healthy Families to review and change a decision to disenroll someone

Instructions

*Use this form if you do not agree with a decision Healthy Families made to disenroll someone in your family. (*Disenroll *means coverage will stop.) You may ask Healthy Families to change the decision; and you may ask to keep your coverage during the review.* ***Fill out the form and mail it so that we receive it by***

Questions?

If you have any questions about the form, call Healthy Families: ***1-866-848-9166*** *Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m. The call is free.*

❑ **Check this box if you are sending new income or other new papers with the form.**

❑ **Check this box if you are including a request for payment of medical bills with the form (please include the bills).**

A. Information about you.

Are your name, address and phone numbers right?

If any of this is wrong, please cross it out. Write the correct information next to it.

FAMILY MEMBER NUMBER:

Day: Evening: Message:

B. Information about the person or persons whose coverage will stop.

C. Reason for review.

1. What is the decision you would like us to review?

Tell about the decision you would like us to review. Or, include a copy of the letter you got from Healthy Families that talks about the decision.

2. Why do you think our decision is wrong?

Write your reason below. Or, check the boxes below. Check as many as you wish.

- ❑ Income was figured wrong
- ❑ Member is not on no-cost Medi-Cal
- ❑ Sent papers that were asked for (tell us below when you mailed or faxed the papers)
- ❑ Payment was made
- ❑ I think decision violates Healthy Families policy or law (explain below)
- ❑ Other (explain below)

3. What would you like us to do?

- ❑ Keep family members in Healthy Families
- ❑ Other (explain below)

4. What else would you like us to know?

Is there any other information you think would help us review our decision? Write the information or send other papers that will help us understand.

D. Sign the form and send it to us by

I am asking to keep coverage during the review. I understand that I must pay my monthly premium payments during the review process. I understand that if I do not make the payments, the members of my family may lose coverage.

Signature: _____ **Date:** _____

Mail the form and other papers to:

Healthy Families
Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005

Or, you can fax the form and papers to:

Fax: 1-866-848-4974 The fax number is free.

Write your Family Member Number on each paper you send. **Your Family Member Number is:**

E. Permission to share information with the following person:

I give permission for the Healthy Families Program to give information over the telephone about the status of this application to a Certified Application Assistant of the Enrollment Entity organization identified. This permission will end on the date the program mails the results of the eligibility determination on this application.

Name: _____

➨ Signature: _____ Date: _____

CAA#: _____ EE#: _____